

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 5. The Illinois Insurance Code is amended by  
5 changing Section 356z.3 and by adding Section 356z.3a as  
6 follows:

7 (215 ILCS 5/356z.3)

8 Sec. 356z.3. Disclosure of limited benefit. An insurer that  
9 issues, delivers, amends, or renews an individual or group  
10 policy of accident and health insurance in this State after the  
11 effective date of this amendatory Act of the 92nd General  
12 Assembly and arranges, contracts with, or administers  
13 contracts with a provider whereby beneficiaries are provided an  
14 incentive to use the services of such provider must include the  
15 following disclosure on its contracts and evidences of  
16 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN  
17 NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that  
18 when you elect to utilize the services of a non-participating  
19 provider for a covered service in non-emergency situations,  
20 benefit payments to such non-participating provider are not  
21 based upon the amount billed. The basis of your benefit payment  
22 will be determined according to your policy's fee schedule,  
23 usual and customary charge (which is determined by comparing

1 charges for similar services adjusted to the geographical area  
2 where the services are performed), or other method as defined  
3 by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE  
4 AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS  
5 REQUIRED PORTION. Non-participating providers may bill members  
6 for any amount up to the billed charge after the plan has paid  
7 its portion of the bill as provided in Section 356z.3a of this  
8 Code. Participating providers have agreed to accept discounted  
9 payments for services with no additional billing to the member  
10 other than co-insurance and deductible amounts. You may obtain  
11 further information about the participating status of  
12 professional providers and information on out-of-pocket  
13 expenses by calling the toll free telephone number on your  
14 identification card."

15 (Source: P.A. 95-331, eff. 8-21-07.)

16 (215 ILCS 5/356z.3a new)

17 Sec. 356z.3a. Nonparticipating facility-based physicians  
18 and providers.

19 (a) For purposes of this Section, "facility-based  
20 provider" means a physician or other provider who provide  
21 radiology, anesthesiology, pathology, neonatology, or  
22 emergency department services to insureds, beneficiaries, or  
23 enrollees in a participating hospital or participating  
24 ambulatory surgical treatment center.

25 (b) When a beneficiary, insured, or enrollee utilizes a

1 participating network hospital or a participating network  
2 ambulatory surgery center and, due to any reason, in network  
3 services for radiology, anesthesiology, pathology, emergency  
4 physician, or neonatology are unavailable and are provided by a  
5 nonparticipating facility-based physician or provider, the  
6 insurer or health plan shall ensure that the beneficiary,  
7 insured, or enrollee shall incur no greater out-of-pocket costs  
8 than the beneficiary, insured, or enrollee would have incurred  
9 with a participating physician or provider for covered  
10 services.

11 (c) If a beneficiary, insured, or enrollee agrees in  
12 writing, notwithstanding any other provision of this Code, any  
13 benefits a beneficiary, insured, or enrollee receives for  
14 services under the situation in subsection (b) are assigned to  
15 the nonparticipating facility-based providers. The insurer or  
16 health plan shall provide the nonparticipating provider with a  
17 written explanation of benefits that specifies the proposed  
18 reimbursement and the applicable deductible, copayment or  
19 coinsurance amounts owed by the insured, beneficiary or  
20 enrollee. The insurer or health plan shall pay any  
21 reimbursement directly to the nonparticipating facility-based  
22 provider. The nonparticipating facility-based physician or  
23 provider shall not bill the beneficiary, insured, or enrollee,  
24 except for applicable deductible, copayment, or coinsurance  
25 amounts that would apply if the beneficiary, insured, or  
26 enrollee utilized a participating physician or provider for

1 covered services. If a beneficiary, insured, or enrollee  
2 specifically rejects assignment under this Section in writing  
3 to the nonparticipating facility-based provider, then the  
4 nonparticipating facility-based provider may bill the  
5 beneficiary, insured, or enrollee for the services rendered.

6 (d) For bills assigned under subsection (c), the  
7 nonparticipating facility-based provider may bill the insurer  
8 or health plan for the services rendered, and the insurer or  
9 health plan may pay the billed amount or attempt to negotiate  
10 reimbursement with the nonparticipating facility-based  
11 provider. If attempts to negotiate reimbursement for services  
12 provided by a nonparticipating facility-based provider do not  
13 result in a resolution of the payment dispute within 30 days  
14 after receipt of written explanation of benefits by the insurer  
15 or health plan, then an insurer or health plan or  
16 nonparticipating facility-based physician or provider may  
17 initiate binding arbitration to determine payment for services  
18 provided on a per bill basis. The party requesting arbitration  
19 shall notify the other party arbitration has been initiated and  
20 state its final offer before arbitration. In response to this  
21 notice, the nonrequesting party shall inform the requesting  
22 party of its final offer before the arbitration occurs.  
23 Arbitration shall be initiated by filing a request with the  
24 Department of Insurance.

25 (e) The Department of Insurance shall publish a list of  
26 approved arbitrators or entities that shall provide binding

1 arbitration. These arbitrators shall be American Arbitration  
2 Association or American Health Lawyers Association trained  
3 arbitrators. Both parties must agree on an arbitrator from the  
4 Department of Insurance's list of arbitrators. If no agreement  
5 can be reached, then a list of 5 arbitrators shall be provided  
6 by the Department of Insurance. From the list of 5 arbitrators,  
7 the insurer can veto 2 arbitrators and the provider can veto 2  
8 arbitrators. The remaining arbitrator shall be the chosen  
9 arbitrator. This arbitration shall consist of a review of the  
10 written submissions by both parties. Binding arbitration shall  
11 provide for a written decision within 45 days after the request  
12 is filed with the Department of Insurance. Both parties shall  
13 be bound by the arbitrator's decision. The arbitrator's  
14 expenses and fees, together with other expenses, not including  
15 attorney's fees, incurred in the conduct of the arbitration,  
16 shall be paid as provided in the decision.

17 (f) This Section 356z.3a does not apply to a beneficiary,  
18 insured, or enrollee who willfully chooses to access a  
19 nonparticipating facility-based physician or provider for  
20 health care services available through the insurer's or plan's  
21 network of participating physicians and providers. In these  
22 circumstances, the contractual requirements for  
23 nonparticipating facility-based provider reimbursements will  
24 apply.

25 (g) Section 368a of this Act shall not apply during the  
26 pendency of a decision under subsection (d) any interest

1 required to be paid a provider under Section 368a shall not  
2 accrue until after 30 days of an arbitrator's decision as  
3 provided in subsection (d), but in no circumstances longer than  
4 150 days from date the nonparticipating facility-based  
5 provider billed for services rendered.